FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0007880

Facility Name: COUNTRY HEALTH

Address: R R 1 Box 14 (Number) Gifford (City) 61938 (Zip Code)

County: Champaign

Telephone Number: (217) 568-7362 **Fax #** ( )

IDPA ID Number: 376064916

Date of Initial License for Current Owners: 01/01/70

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Pam Britt
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) Craig L. Ater
(Firm Name & Address) Heritage Enterprises
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	79	Skilled (SNF)	79	28,835	1
2		Skilled Pediatric (SNF/PED)			2
3	10	Intermediate (ICF)	10	3,650	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,485	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,169	13,431	2,616	27,216	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	11,169	13,431	2,616	27,216	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.78%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 01/01/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,616

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	181,757	9,835		191,592		191,592		191,592			1
2	Food Purchase		120,240		120,240		120,240		120,240			2
3	Housekeeping	79,866	15,529		95,395		95,395		95,395			3
4	Laundry	44,663	6,475		51,138		51,138		51,138			4
5	Heat and Other Utilities			82,172	82,172		82,172		82,172			5
6	Maintenance	57,842	43,558	18,174	119,574		119,574		119,574			6
7	Other (specify):*											7
8	**TOTAL General Services**	364,128	195,637	100,346	660,111		660,111		660,111			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,037,819	82,527	252,829	1,373,175		1,373,175		1,373,175			10
10a	Therapy		102,409	184,470	286,879	(115,040)	171,839		171,839			10a
11	Activities	55,841	5,896		61,737		61,737		61,737			11
12	Social Services	36,774	51	1,668	38,493		38,493		38,493			12
13	Nurse Aide Training	1,209	50		1,259		1,259		1,259			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,131,643	190,933	444,967	1,767,543	(115,040)	1,652,503		1,652,503			16
	C. General Administration											
17	Administrative	56,216			56,216		56,216		56,216			17
18	Directors Fees											18
19	Professional Services			129,056	129,056		129,056	(1,372)	127,684			19
20	Dues, Fees, Subscriptions & Promotions			105,681	105,681	(48,728)	56,953	(34,985)	21,968			20
21	Clerical & General Office Expenses	125,651	10,712	11,830	148,193		148,193		148,193			21
22	Employee Benefits & Payroll Taxes			356,048	356,048		356,048		356,048			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			9,558	9,558		9,558	(7,559)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			124,798	124,798		124,798		124,798			26
27	Other (specify):*			36,929	36,929		36,929	(36,523)	406			27
28	**TOTAL General Administration**	181,867	10,712	775,899	968,478	(48,728)	919,750	(80,439)	839,311			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,677,638	397,282	1,321,212	3,396,132	(163,768)	3,232,364	(80,439)	3,151,925			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number COUNTRY HEALTH #0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			103,956	103,956		103,956		103,956			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,178	21,178		21,178	(289)	20,889			35
36	Other (specify):*											36
37	**TOTAL Ownership**			125,134	125,134		125,134	(289)	124,845			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					115,040	115,040		115,040			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					48,728	48,728		48,728			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					163,768	163,768		163,768			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,677,638	397,282	1,446,346	3,521,266		3,521,266	(80,728)	3,440,538			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(289)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(195)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,559)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,372)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,523)	27		24
25	Fund Raising, Advertising and Promotional	(34,790)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (80,728)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (80,728)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

COUNTRY HEALTH

ID# 0007880

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		(289)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(195)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,372)	19	22
23				23
24		(36,523)	27	24
25		(34,790)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(73,169)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRY HEALTH # 0007880 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,372)	0	0	0	0	0	0	0	0	0	0	(1,372)	19
20	Fees, Subscriptions & Promotions	(34,985)	0	0	0	0	0	0	0	0	0	0	(34,985)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,559)	0	0	0	0	0	0	0	0	0	0	(7,559)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(36,523)	0	0	0	0	0	0	0	0	0	0	(36,523)	27
28	**TOTAL General Administration**	(80,439)	0	0	0	0	0	0	0	0	0	0	(80,439)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(80,439)	0	0	0	0	0	0	0	0	0	0	(80,439)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRY HEALTH # 0007880 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(289)	0	0	0	0	0	0	0	0	0	0	(289)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(289)	0	0	0	0	0	0	0	0	0	0	(289)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(80,728)	0	0	0	0	0	0	0	0	0	0	(80,728)	45

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Interest Income											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COUNTRY HEALTH COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0007880

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 27,031	1
2					2
3	TOTALS			$ 27,031	3

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	89				$ 744,720	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1976 Improvements			1976	10,703						9
10	1977 Improvements			1979	15,361						10
11	1978 Improvements			1977	25,766						11
12	1979 Improvements			1978	6,618						12
13	1980 Improvements			1980	30,846						13
14	1981 Improvements			1981	18,567						14
15	1982 Improvements			1982	4,662						15
16	1983 Improvements			1983	28,833						16
17	1984 Improvements			1984	6,700						17
18	1985 Improvements			1985	33,953						18
19	1986 Improvements			1986	23,775						19
20	1987 Improvements			1987	40,603						20
21	1988 Improvements			1988	163,565						21
22	1989 Improvements			1989	50,581						22
23	1990 Improvements			1990	111,695						23
24	1991 Improvements			1991	36,516						24
25	1992 Improvements			1992	26,816						25
26	1993 Improvements			1993	21,383						26
27	1994 Improvements			1994	12,384						27
28	1995 Improvements			1995	5,450						28
29	NURSE CALL SYSTEM			1996	6,349						29
30	DINNING ROOM EXPANSION			1996	10,109						30
31	Dinning Room Remodel			1997	6,121						31
32											32
33											33
34	C/O Allocation										34
35	Book Depreciation					57,129		57,129		1,221,847	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dinning Room Remodel	1998	$ 212,044	$		$	$	$	37
38	Resident Room Remodel	1998	63,596						38
39	Generator Regulator	1998	2,706						39
40	Chiller/Air Conditioner	1998	1,088						40
41	Threshold Improvement	1998	1,028						41
42	Garbage Disposal	1998	1,170						42
43	Wanderguard	1998	2,132						43
44	Landscaping	1998	1,271						44
45	Gas Line	1998	1,445						45
46									46
47	Lobby Remodel-- Materials /Labor	1999	15,320						47
48	Concrete Border	1999	1,750						48
49	Landscapping	1999	1,468						49
50	Soffit & Fascia Replacement	1999	7,839						50
51	Dinning Room Project	1999	74,106						51
52	Resident Room Remodel	1999	21,649						52
53									53
54	Bathroom remodel -- labor and materials	2000	9,750						54
55	Smoke Detectors	2000	2,248						55
56	Room Remodel -- labor and materials	2000	4,030						56
57	Exhaust Fan	2000	1,047						57
58	Hallway Flooring	2000	10,189						58
59	Bathroom Flooring	2000	1,350						59
60	Drapes --Lobby	2000	1,361						60
61									61
62	Ceramic Tile Shower	2001	698						62
63	Hot Water Pump	2001	2,586						63
64	Carpeting and Installation	2001	2,208						64
65	Wander Guard	2001	1,270						65
66	Light Fixtures and Door	2001	2,777						66
67	Flooring	2001	1,311						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,891,513	$ 57,129		$ 57,129	$	$ 1,221,847	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,891,513	$ 57,129		$ 57,129	$	$ 1,221,847	1
2									2
3	Furnace	2002	2,262						3
4	Boiler	2002	4,045						4
5	Resident Room Remodel--Paint, flooring, drapes	2002	5,229						5
6	Dry Pendent	2002	477						6
7	Door Alarm System	2002	688						7
8	Smoke Detection System	2002	2,990						8
9	Courtyard Improvements	2002	25,600						9
10	A/C Laundry Room	2002	771						10
11	Signage	2002	1,336						11
12	Sprinkler	2002	1,190						12
13									13
14	Courtyard Improvements	2003	1,708						14
15	Shed	2003	2,259						15
16	Resident Room Remodel--Paint, flooring, drapes	2003	12,250						16
17	Wander Guard	2003	1,897						17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,954,215	$ 57,129		$ 57,129	$	$ 1,221,847	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 645,063	$ 46,827	$ 46,827	$		$ 573,359	71
72	Current Year Purchases	32,669						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 677,732	$ 46,827	$ 46,827	$		$ 573,359	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1983 Chevy Van	1983	$ 18,305	$	$	$		$	76
77		1985 Ford	1992	6,000						77
78		1996 DODGE VAN	1996	25,500						78
79										79
80	TOTALS			$ 49,805	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,708,783	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,956	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 103,956	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,795,206	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 20,889 Description: pager, computer equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		50		50
3	Classroom Wages (a)		1,209		1,209
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,259	$	$ 1,259
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,259			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 81,807	$		$ 81,807	1
2	Licensed Speech and Language Development Therapist		hrs			6,612			6,612	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			80,227	3,193		83,420	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				99,216		99,216	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					15,824			15,824	13
14	TOTAL			$		$ 184,470	$ 102,409		$ 286,879	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number COUNTRY HEALTH **#** 0007880 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 335,241	$	1
2	Cash-Patient Deposits	7,795		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	296,576		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,432		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 668,044	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,031		13
14	Buildings, at Historical Cost	1,966,272		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	715,479		16
17	Accumulated Depreciation (book methods)	(1,795,206)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	(12,635)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 900,941	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,568,985	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 95,199	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,795		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,902		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,626		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Escrow			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 236,522	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 236,522	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,332,463	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,568,985	$	48

***(See instructions.)**

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,312,536	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,312,536	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	19,927	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 19,927	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,332,463	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,493,017	1
2	Discounts and Allowances for all Levels	(633,055)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,859,962	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	490,573	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 490,573	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,104	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	161,392	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,473	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 165,969	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,514	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,514	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,519,018	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	660,111	31
32	Health Care	1,767,543	32
33	General Administration	968,478	33
	B. Capital Expense		
34	Ownership	125,134	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		(22,175)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,499,091	40
41	**Income before Income Taxes (line 30 minus line 40)****	19,927	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 19,927	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,912	2,048	$ 47,504	$ 23.20	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	7,203	8,046	143,413	17.82	3
4	Licensed Practical Nurses	5,573	6,358	88,659	13.94	4
5	Nurse Aides & Orderlies	51,669	56,635	653,514	11.54	5
6	Nurse Aide Trainees	120	120	1,209	10.08	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,131	6,911	104,729	15.15	8
9	Activity Director					9
10	Activity Assistants	5,923	6,575	55,841	8.49	10
11	Social Service Workers	3,087	3,560	36,774	10.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,785	19,801	181,757	9.18	15
16	Dishwashers					16
17	Maintenance Workers	3,657	4,221	57,842	13.70	17
18	Housekeepers	8,537	9,885	79,866	8.08	18
19	Laundry	4,909	5,504	44,663	8.11	19
20	Administrator	2,080	2,080	56,216	27.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,923	9,408	125,651	13.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,509	141,152	$ 1,677,638 *	$ 11.89	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		6,000		36
37	Medical Records Consultant		1,480		37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,643		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,449		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 10,572		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,476	$ 104,292		50
51	Licensed Practical Nurses	1,154	28,846		51
52	Nurse Aides	5,715	114,307		52
53	TOTAL (lines 50 - 52)	10,346	$ 247,445		53

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pam Britt	Admin	0	$ 56,216
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,216

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 118,244
Principal Financial	401K	1,600
Sulaski & Webb	Audit	7,500
T. Rear	Interpreter	340
		0
Legal Fees (Adjusted to zero)		1,372
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 129,056

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,424
Unemployment Compensation Insurance	24,767
FICA Taxes	128,339
Employee Health Insurance	100,011
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	21,507
Employee Benefits - central office	
TOTAL (agree to Schedule V, line 22, col.8)	$ 356,048

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	14,877
Health Care Worker Background Check	
(Indicate # of checks performed)	378
Central Office Allocation	
Promotional Advertising	30,827
Public Relations	3,963
Dues and Subscriptions	5,923
License and Fees	985
Less: Public Relations Expense	(3,963)
Non-allowable advertising	(195)
Yellow page advertising	(30,827)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,968

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	5,076
	111
Seminar Expense	4,371
Non Allowable	(7,559)
Central Office Allocation	
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **48,728**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **7,214**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Pellman & Dold** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. **Not Complete as of this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount							
1009			PETTY CASH	335,241							1,009	1010 CASH IN B	335,241			
1010			CASH IN BANK								1,100		296,576			
1040			CASH IN BANK-PAYROLL								1,101					
1100			ACCOUNTS RECEIVABLE	296,576							1,110					
1110			MEDICARE RECEIVABLES								1,125					
1125			IPA INCOME RECEIVABLE								1,135					
1130			MEDICARE COST REPORT								1,140					
1135			ACCOUNTS RECEIVABLE-IC								1,145					
1140			UNAPPLIED CASH RECEIPTS								1,200		28,432			
1145			A/R SUSPENSE-REFUNDS								1,220					
1190			ACCRUED INTEREST REC								1,300					
1200			PREPAID INSURANCE	28,432							1,310					
1220			OTHER PREPAID EXPENSES								1,320					
1300			FOOD INVENTORY								1,409		27,031			
1310			SUPPLIES INVENTORY								1,450		715,479			
1409			LAND	27,031							1,460		-573,359			
1450			FURNITURE & EQUIPMENT	715,479							1,475		1,966,272			
1460			ACCUM DEPR-FURN & EQUIP	-573,359							1,490		-1,221,847			
1475			BUILDING & IMPROVEMENTS	1,966,272							1,530		7,795			
1490			ACCUM DEPR-BUILDING	-1,221,847							1,550					
1530			RESIDENT FUNDS	7,795							1,551					
1550			LOAN FEES	0							1,850		-12,634			
1560			REAL ESTATE TAX ESCROW								2,010		-95,199			
1575			REIMBURSABLE PURCHASES								2,100		0			
1850			INTRACOMPANY	-12,634							2,100		-58,255			
2010			ACCOUNTS PAYABLE	-95,199							2,100					
2095			BONUSES PAYABLE								2,100					
2100			ACCRUED PAYROLL	-58,255							2,110		-72,647			
2110			ACCRUED VACATION PAY	-72,647							2,120					
2120			UC TAXES PAYABLE								2,125		-2,626			
2125			FICA TAX PAYABLE	-2,626	-2,626						2,130					
2130			FIT PAYABLE								2,140					
2140			STATE W/H PAYABLE		0						2,152					
2145			EARNED INCOME CREDIT								2,225					
2150			UC FED CREDIT REDUCTION								2,230					
2230			PAYROLL SAVINGS								2,235					
2235			IRA W/HOLDINGS								2,240					
2240			UNITED WAY								2,246					
2245			GROUP INSURANCE PAYABLE								2,250					
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260					
2260			WAGE GARNISHMENTS								2,300					
2280			MISC PAYROLL DEDUCTIONS								2,320					
2300			ACCRUED INTEREST PAYABLE	0							2,350					
2310			SALES TAX PAYABLE								2,385					
2320			IPA PAYMENTS PAYABLE	0							2,400					
2350			REAL ESTATE TAX PAYABLE	0							2,512		-7,795			
2385			ACTIVITY FUND	0							2,600					
2390			SECURITY DEPOSITS								2,600					
2391			VOLUNTEER FUND								2,625					
2393			HEART FUND/BAZAAR								2,625					
2395			DEFERRED INC EMP & MEM								2,695					
2400			CURRENT PORTION LT DEBT								2,720		-1,312,537			
2460			INCOME TAXES PAYABLE									net income	-19,927			
2512			DUE TO RESIDENTS	-7,795												
2600			MORTGAGE PAYABLE	0												
2650			EQUIPMENT LOAN PAYABLE									balance	0			
2695			CURRENT PORTION LT DEBT													
2696			DEFERRED INCOME TAXES													
2710			COMMON STOCK													
2720			RETAINED EARNINGS	-1,312,537												
2970			PROFIT/LOSS FOR PERIOD	-19,927												
3007.1			PATIENT DAYS-PRIVATE	13,496										3,007		13,496
3007.2			PATIENT DAYS-IPA	11,187										3,007		11,187
3007.3			PATIENT DAYS-MEDICARE	2,616										3,007		2,616
3007.4			PATIENT DAYS-CONVERSION											3,007		
3007.5			PATIENT DAYS-LICENSED											3,007		
3007.6			PATIENT DAYS-TOTAL											3,007		
3010		1	BASIC CHARGE-PRIVATE & VA	-1,646,910		0	0	0	0					3,007		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0					3,010	3,010 BASIC CH	(1,646,910)
3020		1	BASIC CHARGE-IPA	-953,091		0	0	0	0					3,020	3,020 BASIC CH	(953,091)
3030		1	BASIC CHARGE-MEDICARE	-792,834		0	0	0	0					3,030	3,030 BASIC CH	(792,834)
3035		4	DAY CARE/HOME CARE			0	0	0	0					3,040		
3040		1	LIGHT NURSING CARE	0		0	0	0	0					3,050		
3050		1	MEDIUM NURSING CARE			0	0	0	0					3,060		
3060		1	HEAVY NURSING CARE			0	0	0	0					3,061		
3061		1	SKILLED NURSING CARE											3,080	3,080 NURSING	(26,235)
3080		1	NURSING SUPPLIES-PRIVATE	-98,647		0	0	0	0					3,081	3,081 NURSING	(59,873)
3081		1	NURSING SUPPLIES-IPA			0	0	0	0					3,082	3,082 NURSING	(9,554)
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0					3,083	3,083 NURSING	(2,985)
3083		1	NURSING SUPPLIES MED PT B											3,100	3,100 DRUGS-MI	(155,067)
3100		17	DRUGS	-161,392		0	0	0	0					3,101	3,101 DRUGS-OT	(6,325)
3101		17	DRUGS-OTHER											3,110	3,110 PHYSICAL	(43,120)
3110		6	PT-PRIVATE	-490,573		0	0	0	0					3,111	3,111 PHYSICAL	(2,640)
3111		6	PT-IPA			0	0	0	0					3,112	3,112 PHYSICAL	(143,000)
3112		6	PT-MEDICARE PART A			0	0	0	0					3,113	3,113 PHYSICAL	(37,623)
3113		6	PT-MEDICARE PART B			0	0	0	0					3,140	3,140 RESPIRAT	(5,086)
3130		1	PUBLIC AID ASSESSMENT INC											3,150	3,150 ST/OT THE	(44,640)
3140		19	LABORATORY INCOME			0	0	0	0					3,151	3,151 ST/OT THE	(2,040)
3150		6	SPEECH/OT-PRIVATE			0	0	0	0					3,152	3,152 ST/OT THE	(158,680)
3151		6	SPEECH/OT-IPA			0	0	0	0					3,153	3,153 ST/OT THE	(53,544)
3152		6	SPEECH/OT-MED PART A			0	0	0	0					3,160	3,162 AMBULAN	(200)
3153		6	SPEECH/OT MED PART B											3,410	3,410 IPA/OTHEI	128,562
3410		2	IPA DISCOUNTS	633,055		0	0	0	0					3,411	3,411 MEDICARI	25,629
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0					3,420	3,420 MEDICARI	475,361
3420		2	MEDICARE DISCOUNTS			0	0	0	0					3,500		
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0					3,520		
3520		16	RENT INCOME	0		6	0	6	0					3,530		
3530		13	BEAUTY SHOP	0		0	0	0	0					3,560		
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0					3,570		
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0					3,590	3,590 EQUIPMEN	(1,535)
3580		12	MANAGEMENT FEES			0	0	0	0					3,595	3,595 RESIDENT	(2,270)
3590		1	EQUIPMENT RENTAL	-1,535		0	0	0	0					3,600	3,600 MISC INCO	(1,203)
3595		21	RESIDENT TRANSPORTATION	-2,270		0	0	0	0					4,110	4,110 G&A WAG	115,672
3600		21	MISC INCOME	-1,203		0	0	0	0					4,111	4,111 ADMINIST	56,216
4110			GENERAL & ADMINIST WAGES	115,672	125,651	21	1	17	0					4,115	4,115 G&A PTO	9,979
4111			ADMINISTRATOR WAGES	56,216	56,216	17	1	0	0					4,120	4,120 EMPLOYE	14,252
4115			VACATION & SICK - G&A	9,979		21	1	0	0					4,125		
4120	4475		EMPLOYEE BENEFITS	17,527	356,048	22	3	0	0					4,130	4,130 EMPLOYE	3,026
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0					4,135	4,135 EMPLOYE	954
4130			EMPLOYEE SCHOLORSHIP WA	3,026		21	1	0	0					4,250	4,250 OFFICE SU	8,131
4135			EMPLOYEE SCHOLORSHIP COS	954		23	3	0	0					4,255	4,255 POSTAGE	1,657
4220			DIRECTORS FEES			18	3	0	0					4,260	4,260 TELEPHON	11,830
4250	4255		OFFICE SUPPLIES	10,712	10,712	21	2	0	0					4,275	4,275 TRAINING	1,999
4260			TELEPHONE	11,830	11,830	21	3	0	0					4,276		
4275			TRAINING & EMPLOYEE DEVL	1,999	1,999	23	3	16	0					4,280	4,280 GENERAL	5,076
4280			GENERAL TRAVEL	5,076	9,558	24	3	16	0					4,281	4,281 MEAL EXP	111
4281			MEAL EXPENSE FOR TRAVEL	111		24	3	19	0					4,285	4,285 EDUCATIO	4,371
4285			EDUCATION & SEMINAR	4,371		24	3	19	-7,559	***				4,289		
4290			HELP WANTED ADVERTISING	14,877	105,681	20	3	0	0	-48,728				4,290	4,290 HELP WAN	14,877
4291			PROMOTIONAL ADVERTISING	30,827		20	3	25	-30,827					4,291	4,291 PROMOTIO	30,827
4292			PUBLIC RELATIONS	3,963		20	3	25	-3,963					4,292	4,292 PUBLIC RI	3,963
4300			LICENSES & FEES	49,713		20	3	17	0					4,300	4,300 LICENSE &	49,713
4310			DUES & SUBSCRIPTIONS	5,923		20	3	17	-195					4,310	4,310 DUES & SU	5,923
4320			CONTRIBUTIONS	0		27	3	20	0					4,320		
4350			PROFESSIONAL FEES	10,812	129,056	19	3	22	-1,372					4,350	4,350 PROFESSI	10,812
4355			MEDICAL DIRECTOR	6,000	6,000	9	3	0	0					4,355	4,355 MEDICAL	6,000
4360			UTILIZATION REVIEW			10	3	0	0					4,362	4,362 MEDICAL	1,480
4361			OTHER PHYSICIAN FEES			39	3	0	0					4,363	4,363 PHARMAC	1,643
4362			MEDICAL RECORDS CONSULT	1,480		10	3	0	0					4,364	4,364 SOCIAL SI	1,449
4363			PHARMACIST FEES	1,643		10	3	0	0					4,370	4,370 TV RENTA	705
4364			SOC SERV/ACT CONSULT	1,449	1,449	12	3	0	0					4,383	4,383 TAX PENA	378
4370			TV RENTAL	705		35	3	5	-289					4,390	4,390 OTHER TA	900
4380			INCOME TAXES		36,929	27	3	26	0					4,400	4,400 PAYROLL	147,271
4383			BACKGROUND CHECKS	378		20	3	26	0					4,401	4,401 PAYROLL	5,835
4400			PAYROLL TAXES	147,271		22	3	0	0					4,410	4,410 GROUP IN	100,011
4401			PAYROLL TAXES ADMINIST	5,835		22	3	0	0					4,420	4,420 LIABILITY	124,798
4410			GROUP INSURANCE	100,011		22	3	0	0					4,430	4,430 WORKMAI	77,932
4420			LIABILITY INSURANCE	124,798	124,798	26	3	0	0					4,435	4,435 W/C-FIRST	3,087
4425			INSURANCE-OWNERS			22	3	21	0					4,436	4,436 DRUG TES	405
4430			WORKMENS COMP INSURANCI	81,424		22	3	0	0					4,450	4,450 MANAGEM	118,244
4450			CENTRAL OFFICE FEES	118,244		19	3	34	0	**				4,460	4,460 BAD DEBT	36,523
4460			BAD DEBTS	36,523		27	3	24	-36,523					4,461	4,461 BAD DEBT	3,503
4470			LOST ITEMS-RESIDENTS	406		27	3	0						4,470	4,470 LOST ITEM	406
4490			MISCELLANEOUS	0		27	3	0	0					4,475	4,475 UNIFORM	3,275
4510			REAL ESTATE TAXES	0	0	33	3	0	0					4,486	4,486 SERVICE C	4,679
4600			LEASED EQUIPMENT	20,473	21,178	35	3	16	0					4,490	4,490 MISC EXPI	452
5110			MAINTENANCE SALARIES	53,582	57,842	6	1	0	0					4,496	4,496 MISC. M.I.	924
5120			MAINTENANCE SICK & VAC	4,260		6	1	0	0					4,510		
5130			ELECTRIC	37,382	82,172	5	3	0	0					4,600	4,600 LEASED E	20,473
5131			NATURAL GAS	30,967		5	3	0	0					5,110	5,110 MAINTEN	53,582
5132			HEATING & DEISEL OIL			5	3	0	0					5,120	5,120 MAINTEN	4,260
5133			WATER & SEWER	13,823		5	3	0	0					5,130	5,130 ELECTRIC	37,382
5134			TRASH COLLECTION	5,450	18,174	6	3	0	0					5,131	5,131 NATURAL	30,967
5140			PROPERTY PLANT REPLACEMI	3,294	43,558	6	2	0	0					5,133	5,133 WATER &	13,823
5160			GENERAL REPAIR & MAINT	40,264		6	2	0	0					5,134	5,134 TRASH CO	5,450
5165			MAINTENANCE CONTRACTS	12,724		6	3	0	0					5,140	5,140 PROP/PLA	3,294
5210			DIETARY WAGES	172,725	181,757	1	1	0	0					5,160	5,160 GENERAL	40,264
5220			DIETARY SICK & VAC	9,032		1	1	0	0					5,165	5,165 MAINTEN	8,045
5240			SALES TAX			2	3	13	0					5,210	5,210 DIETARY	172,725
5248			FOOD PURCHASES	127,454	120,240	2	2	0	0					5,220	5,220 DIETARY	9,032
5250			SUPPLIES-DISHWASHING	2,622	9,835	1	2	0	0					5,248	5,248 FOOD PUR	127,002
5260			DIETARY REPLACEMENT	546		1	2	0	0					5,250	5,250 SUPPLIES	2,622
5270			KITCHEN SUPPLIES-PAPER	6,667		1	2	0	0					5,260	5,260 REPLACE	546
5295			MEAL CREDIT	-7,214		2	2	0	0					5,270	5,270 KITCHEN	6,667
5310			LAUNDRY WAGES	42,379	44,663	4	1	0	0					5,295	5,295 MEAL INC	(7,214)
5340			LAUNDRY SICK & VAC	2,284		4	1	0	0					5,310	5,310 LAUNDRY	42,379
5370			LAUNDRY REPLACEMENT	2,309	6,475	4	2	0	0					5,340	5,340 LAUNDRY	2,284
5380			LAUNDRY REIMBURSEMENT			4	3	0	0					5,370	5,370 REPLACE	2,309
5390			LAUNDRY SUPPLIES	4,166		4	2	0	0					5,380		
5410			HOUSEKEEPING WAGES	74,862	79,866	3	1	0	0					5,390	5,390 SUPPLIES	4,166
5440			HOUSEKEEPING SICK & VAC	5,004		3	1	0	0					5,410	5,410 HOUSEKE	74,862
5480			HOUSEKEEPING SUPPLIES	9,259	15,529	3	2	0	0					5,440	5,440 HOUSEKE	5,004
5490			HOUSEKEEPING SUPPLIES-PPR	6,270		3	2	0	0					5,480	5,480 SUPPLIES-	9,259
6010			RN WAGES-MEDICARE		1,037,819	10	1	0	0					5,490	5,490 SUPPLIES-	6,270
6020			RN WAGES-NON MEDICARE	144,083		10	1	0	0					6,020	6,020 RN WAGE	144,083
6030			DON WAGES	47,504		10	1	0	0					6,030	6,030 DON WAG	47,504
6035			ADON	0		10	1	0	0					6,035		
6040			RN SICK & VACATION	-670		10	1	0	0					6,040	6,040 RN PTO &	(670)
6110			LPN WAGES-MEDICARE			10	1	0	0					6,120	6,120 LPN WAGI	88,841
6120			LPN WAGES-NON MEDICARE	88,841		10	1	0	0					6,140	6,140 LPN PTO &	(182)
6130			LPN WAGES OTHER			10	1	0	0					6,220	6,220 AIDES WA	556,013
6140			LPN SICK & VACATION	-182		10	1	0	0					6,240	6,240 AIDES PTC	97,501
6210			AIDE WAGES-MEDICARE			10	1	0	0					6,245	6,245 CONTRAC	104,292
6220			AIDE WAGES-NON MEDICARE	556,013		10	1	0	0					6,246	6,246 CONTRAC	28,846
6230			WARD CLERKS			10	1	0	0					6,247	6,247 CONTRAC	114,307
6240			AIDE VACATION & SICK	97,501		10	1	0	0					6,250	6,250 NURSE AI	1,209
6245			CONTRACT NURSES-RN	104,292		10	3	0	0					6,255	6,255 NURSE AII	50
6246			CONTRACT NURSES-LPN	28,846		10	3	0	0					6,260	6,260 NURSE AII	(1,104)
6247			CONTRACT NURSES-AIDES	114,307		10	3	0	0					6,270	6,270 REHAB W	97,763
6250			NURSE AIDE TRAINING WAGES	1,209	1,209	13	1	0	0					6,275	6,275 REHAB PT	6,966
6255			NURSE AID TRAINING EXP	50	50	13	2	0	0					6,290	6,290 NURSING	64,631
6260			NURSE AIDE TRAINING REIMB	-1,104		0	0	0	0					6,295	6,295 NURSING	11,904
6270			REHAB WAGES	97,763		10	1	0	0					6,390	6,390 REPLACE	5,992
6275			REHAB SICK & VAC	6,966		10	1	0	0					6,490	6,490 OTHER	2,261
6280			NURSING DEPT EDUCATION			23	3	0	0					7,280	7,280 DRUG PUI	98,216
6290			NURSING SUPPLIES	64,631	82,527	10	2	0	0					7,281	7,281 DRUG PUI	1,000
6295			NURSING SUPPLIES	11,904		10	2	0	0					7,380	7,380 LABORAT	14,618
6390			REPLACEMENT-NURSING	5,992		10	2	0	0					7,391	7,391 AMBULAN	962
6490			NURSING OTHER	2,261	252,829	10	3	0	0					7,393	7,393 OTHER A S	244
7280			DRUG PURCHASES	98,216	102,409	39	2	0	0	***				7,510	7,510 ACTIVITIE	54,836
7281			DRUG PURCHASES-OTHER	1,000		39	2							7,540	7,540 ACTIVITIE	1,005
7380			LABORATORY SERVICES	15,824	184,470	39	3	0	0					7,590	7,590 ACTIVITIE	5,896
7410			HOME HEALTH SALARY			39	1	0	0					7,620	7,620 PHYSICAL	80,227
7440			HOME HEALTH SICK & VAC			39	1	0	0					7,660	7,660 P.T. SUPPL	3,193
7450			HOME HEALTH EXPENSES			39	3	0	0					7,710	7,710 SOCIAL SE	33,732
7510			ACTIVITES WAGES	54,836	55,841	11	1	0	0					7,720	7,720 SOCIAL SE	3,042
7540			ACTIVITIES SICK & VAC	1,005		11	1	0	0					7,730	7,730 SOCIAL SE	51
7590			ACTIVITIES SUPPLIES	5,896	5,896	11	2	0	0					7,740	7,740 OCCUPAT	81,807
7595			ACTIVITIES FEES	0	0	11	3	0	0					7,750	7,750 SOCIAL TI	219
7610			PT WAGES			39	1	0	0					7,770	7,770 SPEECH TI	6,612
7611			PT SICK & VACATION			39	1	0	0					7,820		
7620			PT FEES	80,227		39	3	0	0	***				7,890		
7660			PT SUPPLIES	3,193		39	2	0	0					7,960		
7710			SOCIAL SERVICE WAGES	33,732	36,774	12	1	0	0					8,120		
7720			SOCIAL SERVICE SICK & VAC	3,042		12	1	0	0					8,125		
7730			SOCIAL SERVICE EXPENSES	51	51	12	2	0	0					8,130	8,130 DEPRECIA	103,956
7740			OT FEE	81,807		39	3	0	0	***				8,150		
7750			SOCIAL THERAPIST FEE	219	219	12	3	0	0					9,510	9,510 INTEREST	(2,514)
7770			SPEECH THERAPY FEE	6,612		39	3	0	0	***				9,520	9,520 MISC NON	(23,075)
7800			BEAUTICIAN WAGES		0	40	1	0	0					9,530		
7810			BEAUTICIAN SICK & VAC			40	1	0	0							
7820			BEAUTICIAN FEES	0	0	40	3	0	0							-19,927
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0							
7910			VOLUNTEER COORDINATOR			21	1	0	0							
7940			VOL COORD SICK & VAC			21	1	0	0							
7960			VOL COORD SUPPLIES	0		21	2	0	0							
8100			RENT		0	34	3	0	0							
8120			INTEREST EXPENSE	0	0	32	3	14	0							
8130			DEPRECIATION	103,956	103,956	30	3	9	0							
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	60,773						
9510			INTEREST INCOME	-2,514		32	0	10	0							
9520			MISC NON-OPERATING INCOM	0		0	0	0	0							
9700			INCOME TAXES	-22,175		0	0	0	0							
				3,495,473	3,521,266											
					25,793											
GRAND TOTALS				-19,927					-80,728							
				(NET INCOME)												
				0												

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0
173,113

	G/L	RECAP CENSUS
PP	13,496	13,431
IPA	11,187	11,169
medicare	2,616	2,616
		27,216

IPA BEDHOLDS	18
PP BEDHOLDS	65
PP CONVERS	0